



Title: Suicide in the absence of mental disorder

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Abstract

This paper is the result of two decades of studies by a small group of clinician/academics, with an interest in the aetiology of suicide. We find the notion that all or almost all those who complete suicide are suffering a mental disorder to be too restricting. We developed the concept of Predicament Suicide, in which suicide is conceptualized as an escape from unacceptable predicaments. One of these is painful, unresponsive mental disorder. Another is distressing social circumstances. We have used the public record (historical texts through to newspapers and electronic resources) to demonstrate that people with no evidence of mental disorder may suicide in unacceptable predicaments. We have developed the Operationalized Suicide Predicaments (OPS) framework, a means of classifying suicide. The OPS allows for suicide to be classified (as appropriate) as triggered by social factors. It has been found to have face validity and acceptable correlation. It is hoped the OPS may encourage scholars and clinicians to think beyond the medical model.

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1. Introduction

Suicide is the tenth leading cause of death from a global perspective (Levi et al, 2003), but remains to be incompletely understood.

For half a century, the academic view has been that all, or almost all those who complete suicide are suffering from a mental disorder. This has led to two unfortunate outcomes. First, this view has logically led to all suicide prevention efforts to be focused on the early detection and treatment of mental disorder. Second, in some jurisdictions, when suicides occur they are been frequently followed by attacks by authorities who have accepted that all suicide is the result of mental disorder, and thus the occurrence of a suicide indicates health workers are failing to do their duty.

Most lay people easily accept that people may suicide without having a mental disorder – they point to the occasional deaths of a jilted lover and the suicide of the person with painful incurable disease.

2. The Problem

The social science academic community has refused to accept common sense and has steadfastly maintained that suicide is always or almost always the result of mental disorder. It is necessary to present some of the usually cited 'evidence', to confirm that a problem exists.

This evidence comes from psychological autopsies, in which evidence is taken from all surviving contacts of the deceased (family, friends and medical personnel) and the attempt is then made to determine whether mental disorder was present or absent. In 1960, Dorpat & Ripley examined a series of suicides and concluded that 100% had been the result of mental disorder. In 1984 Robins examined 134 cases and concluded that 94% were the result of mental disorder. In 1997 Mosicki stated that "a psychiatric disorder is a necessary condition for suicide to occur". In 1999 Jamison stated that there is 'unequivocal presence of severe psychopathology by those who die by their own hand". In 2004 Bertolette et al reviewed the psychological autopsy studies and concluded 98% of those who suicided suffered a mental disorder. Also in 2004 Ernst et al examined 10% of cases for whom there was no evidence of psychiatric disorder and concluded that there was "probably have an underlying psychiatric process", which the investigators "failed to detect".

In the face of such evidence, those in authority accepted that suicide was almost exclusively the result of mental disorder. Our group contested this evidence.



3. Issues with the psychological autopsy

The psychological autopsy was seen as being 'scientific' and hence, unassailable. However, shortcomings have been reported.

These are retrospective studies and retrospective studies are not accepted as being of high scientific value in any area of social science. Many (Robbins, 1984) did not include control samples. Those who gather and evaluate the information used in psychological autopsies have an investment in the outcome of these studies, and while we aspire to objectivity, avoiding bias is always a difficult task (Selkin & Loya, 1979). There are different types of psychological autopsy (Scott et al, 2006), leading some authors to state that one study cannot be compared to another (Abondo, et al, 2008). Many authors have raised concern about the validity and reliability (Ogloff and Otto, 1993; Biffel, 1996; Hawton et al, 1998a; Werlang & Botega, 2003, Snider et al, 2006). In addition, Pouliot & De Leo (2006) state that "the vast majority have used ill-defined instruments", which means the formulas used to make the diagnoses of mental disorder in "the vast majority" studies were probably not valid.

In view of these and other objections and the frequent findings in Asia that mental disorder was frequently found to be absent in over 50% of completed suicides (Phillips, 2010), there have been recommendations to standardize psychological autopsies (Conner et al, 2011 & 2012). While this may help in future studies, the impression is now created that the solution to suicide is medical, and will take a long time to correct.

3. Sociological/sociocultural autopsy

Emile Durkheim (1897) wrote what may still be called the most important contribution to suicide studies. While he acknowledged that in some cases, suicide was the result of mental disorder, he contended the major factors were sociological: the ability of society to give the individual values and goals, and the degree of integration (attachment) gained by the individual from society. He described 'anomie' a situation in society where the usual rules and regulations do not apply and people lack a moral compass – he described this occurring during the Industrial Revolution and other periods of social upheaval. It is seen with devastating effect today in the high suicide rate of some disadvantaged indigenous people (Pridmore & Fujiyama, 2009).

Durkheim (1897) also described egoistic suicide. This has been much misunderstood. In egoistic suicide the individual has inadequate 'integration', meaning attachments and support



from society. This of course applies when there is social disorganization (anomie), however, it can also be a function of the individual. Durkheim clearly stated people with neurasthenia (difficulty dealing with the stresses of life) were at greatest danger, he also advised against 'excessive individualism' (an attitude of the individual rather than society, that exposes the individual to lack of support and fellowship).

Space does not allow a full discussion of the work of this genius. The important issue is that he drew attention to the influence of society on the suicide rate. An issue which has been assiduously ignored by those who promote mental disorder as the sole/major factor in suicide. Risk factors are of little use in predicting the suicide of the individual (Caine, 2010; Sher, 2011, Large, 2011; Pridmore, 2011) but epidemiologically, risk factors for community samples can be identified. In addition to mental disorder, the risk factors include being male, single, unemployed, poor (in societies where there is misdistribution of wealth), elderly, physically unwell, excessive use of alcohol. The list of risk factors is extensive, and varies somewhat from one study to the next, but social factors are always found to be important.

The breakdown of an important interpersonal relationship is a clear social risk factor (Wyder et al, 2008; Cupina, 2009; Vieira et al, 2009).

Two decades ago, Shneidman (1993) concluded that suicide was not always the result of mental disorder, but always the result of "intolerable psychological pain". This could arise from a variety of factors, including social factors.

Models have begun to emerge which take a broader view of suicide. The 'Cry of pain/Entrapment' model has been described by Stark et al (2011), in rural settings in Great Britain. Here, in addition to mental disorder and genetic factors, are described the particular stressors related to rural life (such as isolation and social and political exclusion). A similar 'Strain Theory' of suicide has been described by Zhang et al (2011) in rural China. Here, the stressors are listed as relative deprivation, unrealized aspirations and lack of coping skills. It is interesting that these authors claim, "The strain theory of suicide forms a challenge to the psychiatric model popular in the West". Many in the West applaud such efforts.

Recently a 'Sociological Autopsy' has been described by Scourfield et al (2010), which draws on the tradition of psychological autopsies. They recommend the use of coroner's files, which in spite of some limitations, contain a wealth of relevant information. This group (Shiner et al, 2009) used the sociological autopsy to demonstrate that for mid-life men, that when investments fail and social bonds are broken, suicide may offer a viable escape. A "Sociocultural Autopsy" was reported by Parkar et al (2009) to describe important factors in



suicide in a Mumbai (India) slum. Important factors included victimization of women, problem drinking and the impact of beliefs regarding possession and sorcery.

4. Predicament suicide

Our group developed the concept of "Predicament Suicide" (Pridmore, 2009). A predicament is an uncomfortable position from which escape is difficult if not impossible, and suicide is an escape option.

We suggest there are (for the sake of discussion), two main triggers for suicide, 1) where there is painful mental disorder which is unresponsive or untreated, and 2) where the major trigger for suicide is social factors.

The first of these triggers, mental disorder, is well established as a trigger. Suicide is more common among those with than without mental disorder. For example, the life-time risk of suicide for those with major depressive disorder is around 3-4% (Blair-West & Mellsop, 2001), while the life-time risk for people with schizophrenia may be as high as 9-13% (Pinikahana et al, 2003).

We were interested in searching for evidence of social factors as the trigger for suicide. We closely studied the public record (historical texts through to newspapers and electronic resources) for accounts of suicide in people with no apparent history of mental disorder.

We studied Ovid's "The Metamorphoses", about 250 Mediterranean stories from mythic times to about the 8th century BCE (Pridmore & Majeed, 2011). There are 15 accounts of suicide, predominantly by humans, but also by a god, a nymph and a centaur, none of whom were stated to have suffered a mental disorder. The motives were numerous and included loss of a loved individual, physical pain, defeat and loss of status. The Metamorphoses is an important place in Western culture, and the attitudes and examples contained therein are influential.

We also studied Old Norse and Finnish folk stories (Pridmore et al, 2011). The Poetic Edda described one example, and The Kalevala described three examples of suicide by people, none of whom were stated to have suffered mental disorder. The motives include escape by a young woman from marriage to an aged man, and guilt. These stories have represented in visual art and music and have influenced the thinking of the people of the region.

We studied suicide in the West by examining 10 suicides by public figures from one to three millennia ago, and 10 suicides of public figures of the last 3 decades (Pridmore & McArthur, 2009). A comparison revealed the same motives: shame, guilt, sorrow and anger. We were



able to trace the story of the first 10 people through to the time of the second 10 people through paintings, sculpture, prose, poetry, songs, opera, theatre and cinema. Thus, we were able to illustrate the means by which suicide has been transmitted through Western culture to the present time.

We studied the public record of the suicide of 18 people who died in recent decades and found that loss of reputation was the triggering event (Pridmore & McArthur, 2008). We found on the public record, 15 accounts of people who had suicided in the aftermath of huge financial loss (Pridmore & Reddy, 2012). While these people would have suffered loss of reputation to some degree, this was compounded by other significant material losses. We found from the public record, 20 examples of men who had completed suicide immediately after being apprehended for paedophilia (Walter & Pridmore, in press). While these men suffered reputation loss, they also faced incarceration and further harassment.

We studied the public record of the suicide of 12 couples who died by suicide (pact; Pridmore & Reddy, 2010). Seven (over half) of these cases involved old people, and in each case, one or both of the individuals were suffering terminating or painful chronic disease. A smaller group of young people who had a history of or had been charged with violent acts was also described.

Predicament Suicide is conceptualized as escape from an unacceptable predicament. There are two main triggers, 1) painful unresponsive or untreated mental disorder, and 2) social factors/stressors. That painful mental disorder predisposes to suicide is beyond doubt. The above paragraphs detail studies which we contend that establish beyond doubt, that suicide may be triggered by social factors/stressors.

5. Protest suicide

Recently we have studied the public record with respect to people who have suicided as a protest/political statement (Pridmore & Walter, in press). There are 100-200 cases reported (usually by self-immolation), and this appears to be a discrete entity. Accordingly we have added the words "or attempt to change" to our earlier definition. Predicament Suicide may be better conceptualized as a means to escape or attempt to change an unacceptable predicament.

6. Operationalized Predicament Suicide (OPS)



We have recently operationalized predicament suicide (OPS) by an arrangement of 4 categories, which may assist in the conceptualization and classification of triggers/drivers of suicide (Pridmore et al, in press):

- Category (Cat) A. A mental illness is clearly or probably present, and probably played a major role in triggering the suicide. No environmental/social (non-mental illness) stressor played a major role.
- Cat B. An environmental/social (non-mental illness) stressor/s is clearly or probably present, which probably played a major role in triggering suicide. No mental illness played a major role. For current purposes, terminal illness and intractable pain are considered as 'external' stressors.
- Cat C (combined).
Mental illness and environmental/social (non-mental illness) stressors are both present, and both probably played a role in triggering the suicide. In these circumstance it is difficult to decide which (if either) was the main trigger for the suicide. If the influence of one is clearly predominant and the other is clearly trivial, another category may be chosen.
- Cat U (unclassifiable).
There is insufficient or contradictory information. Also, if there is no evidence for either mental illness or environmental/social (non-mental illness) stressor, this is the appropriate designation. Cat U can be used when dealing with uncertainty.

As a result of subsequent investigations, we are considering adding a 5th category, Cat P, to accommodate protest suicide. However, although there are over 100 cases of protest/political suicide on the public record, they are extremely rare and none have been encountered in the clinical experience of the first author.

In Pridmore et al (in press), 18 experienced psychiatrists (from six different countries) read 12 coroner's reports and categorized them according to the OPS. There was acceptable correlation and the raters found the OPS had face validity and was easy to use. It is hoped the OPS will give people the opportunity to take a broader view of suicide, and ease them away from the belief that all those who suicide do so as a result of mental disorder (although, of course, mental disorder is often an important trigger).

6. Discussion



This is an account of the thinking about suicide of a small group of people over a period of two decades. The central theme is that the current social science view that all or almost all those who suicide do so as a consequence of mental disorder. While mental disorder is an important factor, it is not the only factor, and focusing on the medical approaches will not serve the community well. As expected, suicide prevention strategies which focus on medical aspects have failed to reduce suicide rates anywhere around the world (De Leo & Evans, 2004; Page et al, 2012). It is time to rethink the role of mental illness in suicide (Phillips, 2010).

We have introduced the concept of predicament suicide, which holds that individuals use suicide to escape (in rare instances, change) unacceptable predicaments/circumstances.

We have given evidence of people taking their lives to avoid loss of reputation, loved ones, health, and finances. Our methods of using the public record (historical texts through to newspapers and electronic resources) can be criticized as not being sufficiently 'scientific', which is to say, there is no place in science for common sense. Such records contain a vast volume of valuable information.

We have developed an objective system (Operationalized Predicament Suicide; OPS) which can be used to classify suicide, it has 4 categories, one of which allows the suicide to be classified as due to social factors. It is hoped the existence of the OPS will encourage scholars and clinicians to take a broader view of suicide other than the predominant suicide-is-always-due-to-mental-disorder view.

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References

- Abondo M, Masson M, Le Gueut M, Milleet B. [Psychiatric autopsy: its uses and limits in France.] (French). *Encephale* 2008; 34:343-346.
- Bertolote J, Fleischmann A, De Leo, D, Wasserman D. Psychiatric diagnoses and suicide: revisiting the evidence, *Crisis* 2004; 25:147-155.
- Biffel, E. Psychological autopsies: do they belong in the courtroom? *American Journal of Criminal Law* 1996; 24: 123-146.



- Blair-West G, Mellso G. Major depression: does a gender-based down-rating of suicide risk challenge its diagnostic validity? *Australian and New Zealand Journal of Psychiatry* 2001; 35:322-328.
- Caine E. Preventing suicide is hard to do. *Psychiatric Services* 2010; 61:1171.
- Conner K, Beautrais A, Brent D, Conwell Y, Phillips M, Schneider B. The next generation of psychological autopsy studies. Part I. Interview content. *Suicide and Life Threatening Behavior* 2001; 41:594-613.
- Conner K, Beautrais A, Brent D, Conwell Y, Phillips M, Schneider B. The next generation of psychological autopsy studies: Part 2. Interview procedures. *Suicide and Life Threatening Behavior* 2012; 42:86-103.
- Cupina D. Live events, gender and suicidal behaviors in the acute community setting. *Australasian Psychiatry* 2009; 17:233-236.
- De Leo D, Evans R. *International Suicide Rates and Prevention Strategies*. Cambridge, MA: Hogrefe & Huber. 2004.
- Dorpat T, Ripley H. A study of suicide in the Seattle area. *Comprehensive Psychiatry* 1960; 1:349-359.
- Durkheim E. *Suicide: A Study in Sociology*, Free Press, New York. (Originally published in French in 1897; translated and published in English in 1951.)
- Ernst C, Lalovic A, Lesage A, Seguin M, Tousignant M, Turecki G. Suicide and no axis I psychopathology. *BMC Psychiatry* 2004; 30:7.
- Hawton K, Appleby L, Platt S, Foster T, Cooper J, Malmberg A. The psychological autopsy approach to studying suicide: a review of methodological issues. *Journal of Affective Disorders* 1998; 50:269-276.
- Jamison K. *Night falls fast: Understanding suicide*. New York: Vintage books, 1997.
- Large M, Ryan C, Nielssen O. The validity and utility of risk assessment for inpatient suicide. *Australasian Psychiatry* 2011; 19:507-512.
- Mosciki E. Identification of suicide risk factors using epidemiologic using epidemiological studies. *Psychiatric Clinics of North America* 1997; 20:499-517.
- Ogloff, J, Otto R. Psychological autopsy: clinical and legal perspectives. *St Lewis Law Review* 1993; 37:607-646.
- Page A, Taylor R, Gunnell D, Carter G, Morrell S, Martin G. Effectiveness of Australian youth suicide prevention initiatives. *British Journal of Psychiatry* 2011;199:423-429.



- Phillips M. Rethinking the role of mental illness in suicide. *American Journal of Psychiatry* 2010; 167:731-733.
- Pinikahana J, Happell B, Keks N. Suicide and schizophrenia: a review of the literature for the decade (1990-1999) and implications for mental health nursing. *Issues in Mental Health Nursing* 2003; 24:27-43.
- Pouliot L, De Leo D. Critical issues in psychological autopsy studies', *Suicide and Life-Threatening Behavior* 2006; 35:491-510.
- Pridmore S. Suicide risk factors for NSW. *Australian and New Zealand Journal of Psychiatry* 2011; 45:601-602.
- Pridmore S, Fujiyama H. (2009). Suicide in the Northern Territory (Australia) 2001-2006. *Australian and New Zealand Journal of Psychiatry* 2009; 43,1126-1130.
- Pridmore S, Majeed Z. The suicides of The Metamorphoses'. *Australasian Psychiatry* 2011; 19:22-24.
- Pridmore S, McArthur M. Suicide and reputation damage. *Australasian Psychiatry* 2008; 16:312-316.
- Pridmore S, McArthur M. Suicide and Western culture. *Australasian Psychiatry* 2009; 17:42-50.
- Pridmore S, Reddy A. Suicide by couples from the public record. *Australasian Psychiatry* 2010; 18:431-436.
- Pridmore S, Reddy A. Financial loss and suicide. *Malaysian Journal of Medical Science* 2012; 19:74-76.
- Pridmore S, Walter G. Protest suicide. *Australasian Psychiatry*, in press.
- Pridmore S, Ahmadi J, Majeed Z. Suicide in Old Norse and Finnish folk stories. *Australasian Psychiatry* 2011; 19:321-324.
- Pridmore S, Kuipers P, Majeed Z, Restifo S, Lee A, Appleton J. A pilot investigation of the operationalized predicaments of suicide (OPS) framework. *Malaysian Journal of Medical Science*, in press.
- Robins, E. *The Final Months. A study of the lives of 134 persons who committed suicide.* Oxford: Oxford University Press. 1984.
- Scott C, Swartz E, Warburton K. (2006). The psychological autopsy: solving the mysteries of death. *Psychiatric Clinics of North America* 2006; 29:805-822.
- Schnidman E. Suicide as psychache. *Journal of Nervous and Mental Disease* 1993; 181:145-147.



- Scourfield J, Fincham b, Langer S, Shiner M. Sociological autopsy: an integrated approach to the study of suicide in men. *Social Science and Medicine* 1012;74:466-473.
- Selkin J, Loya F. Issues in the psychological autopsy of a controversial public figure. *Professional Psychology* 1979; 19:87-93.
- Sher L. Is it possible to predict suicide? *Australian and New Zealand Journal of Psychiatry* 2011; 45:342.
- Viera L, Freitas M, Pordeus A, Lira S, Silva J. ['Broken hearted teenagers': adolescents that had gone through suicide attempt.] [Portugese] *Cien Saude Colet.* 2009;14:1825-1834.
- Walter G, Pridmore S. Suicide and the publicly exposed pedophile. *Malaysian Journal of Medical Science*, in press.
- Wyder M, Ward P, De Leo. Separation as a suicide risk factor. *Journal of Affective Disorders* 2009; 116:208-213.
- Shiner M, Scourfield J, Rincham B, Langer S. When things fall apart: gender and suicide across the life-course. *Social Science and Medicine* 2009; 69:738-746.
- Snider J, Hane S, Berman A. Standardizing the psychological autopsy: addressing the Daubert standard. *Suicide and Life-Threatening Behavior* 2006; 36:511-518.
- Stark C, Riordan V, O'Connor R. A conceptual model of suicide in rural areas. *Rural Remote Health* 2011; 11(2):1622.
- Werlang S, Botega N. A semistructured interview for psychological autopsy: an inter-rated reliability study. *Suicide and Life-Threatening Behavior* 2003; 33326-330.
- Zhang J, Wiczorek W, Conwell Y, Ming Tu X. Psychological strains and youth suicide in rural China. *Social Science and Medicine* 2011; 72:2003-2009.